Date: _____

Title: _____ Name: _____ DOB: _____ Age: _____ MRN: _____

REASON FOR EXAM TODAY:

EYE HISTORY: [ ] None [ ] Glasses [ ] Contact Lenses

Last Eye Exam: _____

Have you had or has a family member had:

Glaucoma	☐ You	☐ Family
Macular Degeneration	☐ You	☐ Family
Cataracts	☐ You	☐ Family
Retinal Detachment	☐ You	☐ Family
Amblyopia (lazy eye)	☐ You	☐ Family
Dry Eyes	☐ You	☐ Family
Keratoconus	☐ You	☐ Family
Other:_____	☐ You	☐ Family

OTHER MEDICAL INFORMATION

☐ Received Flu Vaccine
☐ Received Pneumococcal Vaccine
☐ Any Recent Falls

GENERAL HEALTH

Primary Care Provider: _____

Have you had or has a family member had:

High Blood Pressure	☐ You	☐ Family _____
Heart Problem (type)	☐ You	☐ Family _____
Arthritis (type)	☐ You	☐ Family _____
Lung Problems (type)	☐ You	☐ Family _____
Stroke (date)	☐ You	☐ Family _____
Thyroid Problems (type)	☐ You	☐ Family _____
Diabetes (type)	☐ You	☐ Family _____
LDL (High Cholesterol)	☐ You	☐ Family _____
Ulcers (where)	☐ You	☐ Family _____
Cancer (type)	☐ You	☐ Family _____
Other (migraines, seizures, Multiple Sclerosis, autoimmune disorder, psychiatric disorder, etc.)	☐ You	☐ Family _____

REVIEW OF SYSTEMS (do you CURRENTLY have any of the following symptoms or conditions)

*** CIRCLE ALL THAT APPLY **OR** CIRCLE NONE ***

ALLERGIC/IMMUNOLOGIC & BLOOD/LYMPHATIC

Infection ☐ Anemia ☐ Seasonal Allergies ☐
Swollen Glands ☐ Hay Fever ☐ Non-Healing Wounds ☐
Other (list) _____
None ☐

CONSTITUTIONAL & INTEGUMENTARY

Night Sweats ☐ Hives/Rashes ☐ Skin Cancer ☐
Fever ☐ Chills ☐ Weight Gain/Loss over 10lbs ☐
Other (list) _____
None ☐

GENITOURINARY

Blood in Urine ☐ Kidney Stones ☐ Painful Urination ☐
Discharge Other (list) _____
None ☐

NEUROLOGICAL, PSYCHIATRIC & MUSCULOSKELETAL

Stroke ☐ Headaches ☐ Migraines ☐
Joint Redness ☐ Swollen Joints ☐ Multiple Sclerosis ☐
Gout ☐ Paralysis ☐ Tingling ☐
Seizures ☐ Arthritis ☐ Tremors ☐
Joint Ache ☐ Anxiety ☐ Depression ☐
Weakness ☐ Numbness ☐ Muscle Pain ☐
Malaise ☐ Dizziness ☐ Hallucinations ☐
Other (list) _____
None ☐

ENDOCRINE

Hair Loss ☐ Diabetes ☐ Appetite Changes ☐
Heat/Cold Intolerance ☐ Increased Urination ☐
Thyroid Problems (list) _____
None ☐

CURRENT PHARMACY NAME AND ADDRESS: (required)

_____

CARDIOVASCULAR

Chest Pain/ Angina ☐ High Cholesterol ☐ Palpitations ☐
High Blood Pressure ☐ Low Blood Pressure ☐ Heart Murmur ☐
Arrythmia (Irregular ♡ beat) ☐ Other: _____
None ☐

GASTROINTESTINAL

Hepatitis/Jaundice ☐ Vomiting/Nausea ☐ Abdominal Pain ☐
Appetite Changes ☐ Bowel Changes ☐ Heartburn ☐
Other (list) _____
None ☐

EYES (HEAD/NECK)

Glare/Halos ☐ Vision Loss ☐ Itching/Irritated ☐
Redness ☐ Swollen Lids ☐ Growths/Lesions ☐
Tearing/Watering ☐ Discharge ☐ Light Sensitivity ☐
Pain/Ache ☐ Dryness ☐ Floaters/Flashes ☐
Burning ☐ Double Vision ☐ Droopy Lid ☐
Foreign Body Sensation ☐ Gritty/Sandy ☐ Hazy/Cloudy ☐
Black Spots ☐ Amblyopia/Lazy Eye ☐ Cobwebs ☐
Other: _____

EARS, NOSE, THROAT (HEAD/NECK)

Hearing Loss ☐ Oral Ulcers ☐ Sinus Infection ☐
Nose/Throat Problems ☐ Other (list) _____
None ☐

RESPIRATORY

Shortness of Breath ☐ Chronic Cough ☐ Pneumonia ☐
Bronchitis ☐ Asthma ☐ Other (list)_____
None ☐

Any other medical condition? _____

SOCIAL HISTORY:

Smoking History? Y / N Do you consume alcohol? Y / N

MEDICATIONS

Do you take any medications? Y/N (if yes, please list) _____

Are you allergic to any medications? Y/N (if yes, please list) _____

SURGERY/PROCEDURES

Please list ALL including eye surgery or procedures _____